segment is a recent addition to routine monitoring that may indeed prove useful in some patients, so we have equipped all our operating rooms with this capability. I still stand by my opinion and agree that it is just my opinion.

To settle this issue, I have conducted an unbiased survey of anesthesiology faculty from a well-known university medical center in the Midwest. Of the 48 faculty surveyed, the following results were found:

Pulse oximeter	34
NIBP*	4
ECG	2
No response	8

I rest my case.

*Noninvasive blood pressure monitoring, if no manual blood pressure.

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Discounting Our Future

To the Editor: I read the commentary "On Sale: Future Health Care—The Paradox of Discounting"[1] with interest and alarm. The concept of discounting, nicely graphed at both 5% and 10% to 40 years, is informative yet misleading. There is no discounting percentage that will stay constant for 40 years. These mathematical concepts that will be used by health care economists are abstract theories out of touch with the human condition and the nature of societies.

Rather than use discount rates of 5% or 10%, why not use terms like shortsighted, living for the present, mortgaging your future and your children's future to more accurately portray the real issues? We in the United States are already reaping the "rewards" of discounting the future in health, education, and the general well-being of society. As our society is in the process of collapse, people are living more for the present at the expense of the future. In actuality, the discounting rate (whatever it actually is) is increasing alarmingly. One wonders whether the discount rate stayed stable over the last 40 years of the Roman Empire.

Sarcasm aside, neat formulas to be used by economists on which crucial health care decisions will be based are out of touch with reality and are an extreme disservice to the field of medicine and society as a whole.

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Dr Ganiats Responds

To the Editor: I appreciate the wit Dr Coren applies in his letter regarding the recent article on discounting.[1] As he correctly points out, the current practice of discounting can be misleading. For example, there is little evidence that the discount rate remains constant over a 40-year period; yet, it is common practice to assume a constant discount rate in health policy research. As discussed in the article, such a practice can have a major effect on health policy decisions. Apparently it can also lead to letters to the editor appropriately laced with sarcasm.

The health care system is currently in a cost crisis, and some authors fear the collapse of the system as we know it by the end of the decade. I do not think discounting is the cause of this collapse, any more than I would attribute the fall of the Roman Empire, as referenced by Dr Coren, to the discount rate. Still, the problems presented by inappropriate discounting are potentially substantial, and this justifies further work in the science of discounting. Some of the key questions were listed in the last section of my article. The basic issue is not whether we should discount, but how we should discount. The answer lies in our patients' actual preferences. Many investigators, including our team here at the University of California, San Diego, continue to work on these issues. I agree with Dr Coren that we should make sure the discount rate stays in touch with reality. If not, then we should abandon the use of discounting in favor of a more appropriate model.

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Meta-analyses Revisited

To the Editor: We wish to thank Peter L. Havens, MD, for his editorial ("Meta-analysis Redux: Steroids and Meningitis Revisited")[1] concerning our recent meta-analysis.[2] Although his points were well expressed, the reader may be served by a presentation of views different from Dr Havens regarding two areas that he addressed.

In his editorial, Dr Havens cites a retrospective review of 97 children with pneumococcal meningitis performed by Kennedy, Hoyt, and McCracken.[3] Dr Havens summarizes the study by stating that there were "no statistically significant differences in the neurologic or audiologic sequelae of patients treated with dexamethasone compared with those not so treated."[1] It is true that no significant difference for hearing impairment ($P = .14$) or long-term adverse neurologic outcome ($P = .18$) existed in the study.[3] Kennedy and co-workers also included a calculation of total adverse outcome, which is not mentioned in the editorial by Dr Havens. This calculation, combining audiologic and neurologic sequelae, did reach significance ($P = .033$). The authors stated that it was their belief that corticosteroid therapy is beneficial in infants and children with pneumococcal meningitis. Dr Havens's reference to data from this study may lead readers to conclude that corticosteroid therapy in pneumococcal meningitis is a "bust." The converse, however, seems to be true.

In addition, Dr Havens seeks to compare results between children treated with different antibiotics, specifically those treated with cephalosporins,[4-6] and those treated with ampicillin and chloramphenicol.[7] His concern is that patients treated with cephalosporins experience a greater incidence of neurologic sequelae than those treated with ampicillin or chloramphenicol. While it certainly is important to know if a difference in efficacy exists between antimicrobial therapies,